Vaccine Refrigerator/Freezer Rebate Application

Date rec'd by VMS:_____

Complete and submit to: **Vermont Medical Society, PO Box 1457, Montpelier, VT 05601**

This completed application must be received by October 30, 2011. For consideration, all fields must be completed, practice name and PIN must match those of a VFC/VFA enrolled practice and street address must be provided. A copy of dated invoice or receipt must be attached. Errors in application are the responsibility of the enrolled provider office. Applications that are late, incomplete or illegible will be returned.

Practice PIN Number: _____

Name of Practice: _____

Contact Person *(Office Vaccine Manager)***:**_____

Telephone Number: _____

Email Address: _____

Street Address: _____

Postal Address if Different: _____

Purchase Date (must be between 9/1/10 & 10/30/2011): _____ **Price:** _____

Refrigerator/freezer brand, manufacturer/ model number/capacity):_____

_____

Delivery Date: _____

Location in building (e.g. lab, etc.) _____

My signature acknowledges that funding is provided by the Vermont Department of Health (VDH) Immunization Program. I affirm that all information above is accurate, and the refrigerator/freezer described above will be used for vaccine storage. Furthermore, I agree that my medical practice will purchase another refrigerator/freezer to meet Vermont Vaccines for Children (VFC) & Vaccines for Adults (VFA) vaccine storage requirements if this refrigerator/freezer does not meet those requirements. I agree that no further reimbursement from VDH will be sought if such purchase becomes necessary. I have read the VDH rebate refrigerator freezer requirement document, and I will consult with the Vermont Department of Health Immunization Program if I have questions about vaccine storage requirements.

_____ _____

Physician-in-charge ***printed name*** *Physician-in-charge* ***signature***

_____

Date

Vermont Department of Health Immunization Program
802-863-7638 or 800-640-4374

3/1/2011